Early On® Michigan Individualized Family Service Plan (IFSP) Individualized Educational Program (IEP)

Referral Source to *Early On*®: Phone: **Date of Referral:**

Child's Legal Name:

Current Address:

Date of Birth: **City of Birth**: **Child Identification #** _____ ❑ **Male** ❑ **Female**

Ethnic Heritage: ❑ **Asian American** ❑ **Black or African American** ❑ **Hispanic/Latino**
❑ **American Indian/Alaska Native** ❑ **White** ❑ **Native Hawaiian/Pacific Islander**

Present concerns and/or diagnosis:

School District of Residence: **County**:

Immunizations: **Date of 1st DPT:**

❑ Parent ❑ Guardian ❑ Family Member ❑ Foster Parent ❑ Surrogate Parent

Name:

Address: **City:** **State:** **Zip:**

Telephone: Day: Evenings: **Native Language:**

Interpreter Needed: ❑ **Yes** ❑ **No** | **Interpreter Provided:** ❑ **Yes** ❑ **No**

❑ Parent ❑ Guardian ❑ Family Member ❑ Foster Parent ❑ Surrogate Parent

Name:

Address: **City:** **State:** **Zip:**

Telephone: Day: Evenings: **Native Language:**

Interpreter Needed: ❑ **Yes** ❑ **No** | **Interpreter Provided:** ❑ **Yes** ❑ **No**

Other Family Members	Health Care & Other Providers	Medical Insurance

Service Coordinator: **Telephone:**

Purpose of the IFSP/IEP: ❑ Initial IFSP/IEP ❑ Annual Review ❑ Redetermination of Eligibility

Eligibility: ❑ Established Condition ❑ Developmental Delay ❑ Special Ed Rule#_____

Type of IFSP

❑ Interim IFSP/Date:	❑ Initial IFSP/IEP Date:
❑ 6 Month Review/Date:	❑ Initial IEP/Date: (if applicable)
❑ Transition/Date:	❑ Annual Review/Date:
❑ Other Review Date	
Special circumstances that delayed the IFSP/IEP ≥ 45 days after referral:	

Child's Name: Date of Birth: Date:

Family Information

Complete only if the family has given permission to an interview on the "Consent to Evaluate" Form.

	Family Resources/ Strengths	Family Concerns	Family Priorities
MEDICAL/HEALTH (Doctor, Insurance, Immunizations, Nutrition, Dental, Substance Use, Current Medications, Hearing, Vision)			
EDUCATION/DEVELOPMENT (Rehabilitation Services, Skill Development, School, GED, Technical Training, College, etc.)			
MATERIAL NEEDS (Transportation, Housing, Utilities, Food, Clothing, etc.)			
EMPLOYMENT/FINANCIAL (Work, Income, Budgeting, CSHCS, SSI, etc.)			
LEGAL (Custody-Court Involvement, Legal Aide, Child-Support, Evictions, Civil Disputes, etc.)			
SAFETY (Physical Environment, Domestic Violence, Child Abuse/Neglect, Medical Issues, Mental Health Issues, etc.)			
SOCIAL/LEISURE/SPIRITUAL (Religious Organizations, Cultural, Recreational, Friends, etc.)			
PSYCHOLOGICAL/EMOTIONAL (Respite, Self-Image, Family Relationships, Mental Health, Stress, Loss, etc.)			

Prioritize family concerns/needs by placing a number next to each item in order of priority in the Family Priority column.

Interviewer: _____

Child's Name:	Date of Birth:	Date:
Chronological Age:	If Premature, Adjusted Age:	

Child's Current Developmental Status

Informed clinical opinion to determine eligibility must be based on the integration of all 4 of the following sources of information. (Check all that have been used.)

❑ **Developmental History** ❑ **Health Status** ❑ **Observation of Parent & Child** ❑ **Developmental Evaluation**

❑ Date of *Early On* Multidisciplinary Evaluation_____ Date of MET (if different):_____

❑ See Attached Report incorporating the above 4 sources

Eligibility: **Established Condition:** **Developmental Delay:**

Special Education Category: **Rule #**

Area	Present Level of Development Parent Input	Result of Dev. Evaluation	Method/Tool/Date Person Completing: Name/Title	Family Priority
Health ❑ See Attached Report		❑ Does health effect participation in Early Intervention Activities		
Hearing ❑ See Attached Report		❑ Language needs considered		
Vision ❑ See Attached Report		❑ Braille needs considered		
Fine Motor ❑ See Attached Report		❑ Assistive Technology considered		
Gross Motor ❑ See Attached Report		❑ Assistive Technology considered		
Cognitive/ Thinking ❑ See Attached Report				
Communication ❑ See Attached Report		❑ English proficiency considered ❑ Communication needs considered		
Social/ Emotional ❑ See Attached Report		❑ Positive behavioral supports considered		
Adaptive ❑ See Attached Report		❑ Assistive Technology considered		

Where will this evaluation take place?

Who should be present?

Child's Name:	Date of Birth:	Date:

IEP Goal #

GOAL/OUTCOME STATEMENT – What the parent would like to see happen for this child/family, including:
A – Audience (Person targeted); **B** – Behavior (Procedures to be used); **C** – Criteria ; **D** – Duration (Time line)
Priority: *(Please circle)* 1 2 3 4 5 6 7 8

Progress made on this goal will be reviewed at the "six month review" unless stated otherwise.

Concern of Parent:

Present Status – What is happening now?

Steps/Objectives – To reach this outcome	Method & Criteria of Evaluation	Review Code	Expected Time Frame
Evaluation Schedule: Progress will be evaluated at least every 6 months	1 – New/Revised 2 – Still a need 3 – Partially Accomplished 4 – Accomplished		

Strategies/Methods - for working on this outcome during this child & family's daily routines and activities.	Persons Responsible

If this outcome cannot be met in the natural environment with supplementary supports explain why it cannot not be met there and the timeline for it's inclusion into the child's natural environment. See page 8.

Service Code	Parents Initials	Frequency (how often?) Intensity (How long?)	Individual Or Group	Starting Date	Ending Date	Location Code	Payor

Other Services

To the extent appropriate, the IFSP must document services that are not required or covered under Part C. Listing the non-required services does not mean that those services must be provided, however, their identification can be helpful to both the family and the service coordinator to assist in securing those services, including those through public or private sources. These services must correspond to family identified outcomes.

Service	Outcome #	Start Date Mo/Day/Yr	Duration (months)	Provider Information	Funding

IFSP/IEP Development Team and Contributors

Check Box ❑ indicating IFSP/IEP Team member who can explain the implications of evaluation results

Printed Name & Role		Signature	Agency (if applicable)	Phone	
	* Parent				
	* Parent				
	*Service Coordinator				❑
	*Educational Representitive				❑
	*Special Education teacher / Service Provider				❑
	** Evaluation/.MET Member				❑
					❑

* Indicates a required IFSP/IEP Team Member

** Indicates a member who is required to attend for an initial evaluation, a reevaluation, or to consider a change of disability.

Parent Consent:

- ❑ I/We, as parent(s)/guardian(s), have had *Early On* explained to me/us including my/our rights and possible participation in an evaluation survey.
- ❑ I/We have had the difference between *Early On* and special education explained to us and we/I understand it**.**
- ❑ I/We have helped to develop this plan. ❑ I/We understand and agree with its content. ❑ I/We agree to each of the services I/We have initialed
- ❑ I/We have received a copy of *The Family Guidebook, Family Rights Pamphlet* and/or the *Special Education Procedural Safeguards*

  OR
- ❑ I do not agree with this IFSP & I request mediation and/or an impartial due process hearing

Parent(s) Signature:	Date:
Parent(s) Signature:	
Service Coordinator Signature	

Child's Full Name: Date of Birth: Date:

Educational Accommodations, Modifications and Considerations

❑ The IFSP/IEP Team has considered supplementary aids and services, program modifications, and supports for school personnel required for the child to attain the annual goals. The Team considered accessibility of physical facilities, specialized transportation, assistive technology devices, & assistive technology services.

Service	Frequency/Duration/Condition	Initial Date	Duration Date	Location

❑ This IEP/IFSP Team considered the need for a teacher endorsed in a particular category._____
How will the developmental needs of this child be addressed during the summer months?

IEP/IFSP Team Recommendation

❑ This child is **not eligible** for special education programs/services.
❑ Outlined programs/services to be provided with the following **person assuring implementation** _____
All programs/services/modifications will begin on _____end on_____and continue for: *(choose one)*
❑ One regular school year ❑ An adapted school year
❑ Other (*Specify)* _____ Rationale _____
❑ One or more IEP/IFSP Team members disagree with this recommendation. *(Complete & attach a dissenting report)*

IEP/IFSP Commitment Signatures

Resident District
The resident district assures that the least restrictive/natural environment has been fully considered: (*Choose all that apply)*
❑ **Agrees** with the recommendation of the IEP/IFSP Team and: *(Check all that apply for **eligible** children)*
- O **Assigns** this child to the following program/school & operating district _____
- O **Authorizes** the non-resident district to assign an appropriate school/program and conduct post-initial IEP/IFSP Team meetings.

❑ **Does not agree** with the recommendation of the IEP/IFSP Team and: (*Choose one)*
O Requests **mediation** O Requests a **due process hearing**

Resident District Superintendent/Designee Date:

Non-Resident Operating District
The non-resident operating district assures that the least restrictive/natural environment has been fully considered and: (*Choose all that apply*)
❑ **Agrees** with the recommendation of the IEP/IFSP Team and: *(Check all that apply for **eligible** children)*
- O **Assigns** this child to the following program/school _____
- O **Agrees** to conduct post-initial IEP/IFSP meetings.

❑ **Does not agree** with the recommendation of the IEP/IFSP Team and: *(Choose one)*
O Requests **mediation** O Requests a **due process hearing**

Operating District Superintendent/Designee Date:

Parent/Guardian
I, as parent/guardian, ❑ have had *Early On*® and Special Education explained to me, ❑ have helped to develop this plan & understand its contents, ❑ have received a copy of & understand my Procedural Safeguards *(check all that apply)*
❑ **Authorize** the sharing of information with agencies that will implement this plan.
❑ **Agree** to the content and implementation of this plan, and its referrals
❑ **Do not agree** with the IEP/IFSP and/but: *(Choose one)*
O Will allow it to be used O Requests **mediation** O Request a **due process hearing**
Parent/Guardian Signature: Date:

Parent/Guardian Signature: Date:

Service Coordinator Signature: Date:

The initial IFSP/IEP meeting was held (date):_____
The initial IFSP/IEP form was completed (date):_____

Attendance Not Necessary
The parent and the LEA agree that attendance of the member(s) listed below is not necessary at this IFSP/IEP meeting because the meeting does not involve a modification to, or a discussion of, the member's area of expertise and ❑ The parent and the LEA consent to the excusal; and ❑ The member submits, in writing to the parent and the IFSP/IEP Team, input into the development of the IFSP/IEP
The parent consents to the excusal of: _____ The parent consents to the excusal of: _____ The parent consents to the excusal of: _____
Parent Signature: Date:

Child's Name: Date of Birth: Date:

Justification for Not Providing Services in Natural Environments

Goal #

Early Intervention services must be provided in natural environments (settings that are natural/typical for the child's age peers who have no disabilities) to the maximum extent appropriate and can only be provided in settings other than natural environments **when outcomes cannot be achieved satisfactory** in natural environments.
The IFSP form requires a "justification for early intervention that cannot be achieved satisfactorily in a natural environment". When documenting the justification on the IFSP team must follow these steps:

❑ Explain how and why the IFSP team determined that the child's outcome(s) could not be met if the support/service were provided in the child's natural environment with supplementary supports provided.

❑ Explain how supports/services provided in this setting will be generalized to support the child's ability to function in his/her natural environment;

❑ Develop a plan, with timelines and the supports necessary, to allow the child's outcome(s) to be satisfactorily achieved in his or her natural environments.

Parent Signature:	Date:
Service Coordinator:	Date:

Child's Name:	Date of Birth:	Date:

Review of IFSP/IEP Goals

Review of Outcomes/Goals must be conducted at least every six months OR more frequently if the family requests a review to determine the degree of progress toward achieving outcomes and whether modifications or revision of the outcomes or services is necessary.
The Team will use the following scale to evaluate progress: 1 – Situation changed, outcome not needed;
2 – Situation unchanged, still need outcome; 3 – Outcome partially attained; 4 – Outcome accomplished.

Outcome/Goal # _____ **Team Evaluation** (Use codes from above):

Progress Summary: (What has changed since the Goal & Objectives were last written or reviewed?)

Modifications/Revisions: (What changes need to be made with this Goal and/or Objectives?)

The Existing IEP/IFSP was reviewed and is being revised as appropriate to address:
- ❑ The results of any reevaluation conducted under this section;
- ❑ Information about the child provided to, or by, the parent(s);
- ❑ The anticipated needs of the child;
- ❑ Progress made by the child, or
- ❑ Other matters. _____

❑ I agree to this service modification change.

❑ I participated in the review of this outcome (Initialed and checked by parent)

IFSP/IEP Team Member's Signatures:

Parent:	Date:
Parent:	Date:
Service Coordinator:	Date:
Other (specify):	Date:
Other (specify):	Date: